# Adult Attendant Care Services (21 and over)

**Definition:** Assistance related to the performance of activities of daily living and/or instrumental activities of daily living and personal care which may include hands-on care, of both a medical and non-medical supportive and health-related nature, specific to the needs of a medically stable adult with physical and/or cognitive disabilities who is able to self-direct his/her own care or has a representative that is able to direct his/her care. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Housekeeping activities provided under Adult Attendant Care are specified in the Support Plan and are incidental to the care furnished, or are essential to the health and welfare of the participant. Any community access activities must be directly related to the participant's care and must be specified in the Support Plan. Transportation is not a component of this service.

The unit of service is one hour, provided by one Adult Attendant Care Aide.

**Service Limits:** Adult Attendant Care Services are limited to a maximum of 28 hours per week, based on SCDDSN assessed need. When Adult Attendant Care is authorized in conjunction with Adult Companion and/or Personal Care 2, the combined total hours per week of services may not exceed 28. A week is defined as Sunday through Saturday. Unused units from one week cannot be banked (i.e. held in reserve) for use during a later week.

**Providers:** Adult Attendant Care Services may be provided by independent attendants approved through the UAP Self-directed Attendant Care Program.

Relatives/family members of a waiver recipient may be paid to provide Adult Attendant Care Services only as specified in DDSN policy 736-01-DD.

**Arranging for and Authorizing Services:** If the Service Coordinator determines that a waiver participant is in need of Adult Attendant Care Services, the Service Coordinator should discuss self-directed and/or responsible party care with the participant/representative. The need for the service must be documented in the participant's Support Plan. To assess the need for Adult Attendant Care Services, the Service Coordinator must complete the Personal Care/Attendant Care Needs Assessment (MR/RD Waiver Form 34).

Once Adult Attendant Care Services are chosen and the amount, frequency and duration of the services are determined, Adult Attendant Care Services can be added on the Waiver Tracking System. Adult Attendant Care services are approved at the local level. When the service is approved, the Service Coordinator will make a referral (**not authorize services**) to the UAP Self-directed Attendant Care Program.

As a part of the minimum qualifications, an attendant must receive training and be certified in basic First Aid prior to the provision of Adult Attendant Care Services. The attendant must also receive refresher training every three (3) years. The Service Coordinator and participant/representative will aid the potential attendant in locating an acceptable First Aid training program, and the attendant will demonstrate competency. Once the training is completed, the Service Coordinator will notify UAP and provide documentation that the requirement has been met.

Note: Follow the UAP Attendant Care procedures (available at www.ddsn.sc.gov) for complete details on the referral process.

Once an attendant is located and UAP has approved the "match," Adult Attendant Care Services can be authorized. The authorization is made out to the attendant, not to UAP. The Service Coordinator will fax or mail the Authorization for UAP Attendant Care Services (MR/RD Form A-37) to:

Attendant Care Services
Center for Disability Resources
Department of Pediatrics
USC School of Medicine
Columbia SC 29208
803-935-5250 (fax)

The Service Coordinator will also provide a copy to the participant/representative, to the attendant and to SCDDSN, Director, Cost Analysis. Upon receipt of the Authorization for UAP Attendant Care Services (MR/RD Form A-37), the attendant is authorized to provide the service. This authorization is in effect until a new/revised Authorization for UAP Attendant Care Services (MR/RD Form A-37) is sent or until services are terminated.

The number of units (one unit = one hour provided by one attendant) authorized is based on the participant's needs, as assessed by SCDDSN. The Service Coordinator will authorize the total units for the week (DDSN defines a week as Sunday through Saturday), and the participant/representative and attendant are responsible for negotiating the times of service. When more than one attendant is authorized to provide services, each of them will be authorized for the full number of units needed, as specified on the Personal Care/Attendant Care Needs Assessment (MR/RD Waiver Form 34). The participant/representative will schedule services with the attendant(s), ensuring that the total combined units of service provided by all authorized attendants do not exceed the number of units specified on the Personal Care/Attendant Care Needs Assessment (MR/RD Waiver Form 34). The Service Coordinator will inform the participant and the attendant(s) that reporting services in excess of the number of units authorized will result in non-payment.

**Monitoring Services:** The Service Coordinator must monitor the service for effectiveness, usefulness and participant satisfaction. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following guidelines should be followed when monitoring Adult Attendant Care Services:

- Within two weeks of the start of service, monitoring should be conducted while the service is being provided, unless the Service Coordination Supervisor documents an exception. An exception can only be made when the service is provided in the late evening or early morning hours (between 9:00 pm and 7:00 am).
- Services should be monitored at least once during the second month of service.
- Services should be monitored at least quarterly (i.e. within 3 months of the previous monitoring) thereafter.
- Monitoring should start over as if it is the start of service any time there is a change of provider.
- Monitoring should be conducted on-site at least once annually (i.e. within 365 days of the previous on-site monitoring).
- Except for the initial monitoring, this service may be monitored during a contact with the participant/representative or with the service provider. It may also be monitored during a review of medical assessments/notes regarding treatment provided.

Some questions to consider during monitoring include:

- Do the attendant care time sheets indicate that services are provided as authorized?

- Are all applicable services/tasks being provided as planned?
- Does the attendant show the participant courtesy and respect?
- Has the participant's health status changed since your last contact? If so, does the service need to continue at the level at which it has been authorized?
- Is the participant/representative pleased with the service being provided, or is assistance needed in obtaining a new provider?
- Does the participant/representative feel that the provider is responsive to the participant's needs?
- Does the participant/representative feel that there is a good relationship with the attendant?

**Reduction, Suspension or Termination of Services:** If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

# Mental Retardation/Related Disabilities Waiver
# Personal Care (PC 1 and PC 2)/Attendant Care Needs Assessment

**MR/RD Waiver Participant:** _____

**Social Security Number:** _____

**Age:** __ **Service(s) Requested** ☐ PC 1 ☐ PC 2 ☐ Attendant Care

## I. Personal Care Needs/ Assistance Required/ Frequency and Time Required

| | | |
|---|---|---|
| Bath: Bed ☐ Shower/Tub ☐ | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| Shaving: | Partial ☐ Total ☐ | __ X Daily, 15 Min ☐ Other _____ |
| Oral Hygiene: | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Skin Care: | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Dressing and Grooming: | Partial ☐ Total ☐ | __ X Daily, 15 Min ☐ Other _____ |
| Incontinence Care: | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| Toileting: | Partial ☐ Total ☐ | __ X Daily, 15 Min ☐ Other _____ |
| Positioning and Turning in Bed: | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Medication Monitoring: | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Other Medical Monitoring: | | |
| _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |
| _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |
| Exercise: | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| Transfers: | | |
| Hoyer ☐ | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Sliding Board ☐ | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Lift System ☐ | Partial ☐ Total ☐ | __ X Daily, 10 Min ☐ Other _____ |
| Other _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |
| Other Personal Care Needs: | | |
| _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |
| _____ | Partial ☐ Total ☐ | Frequency, Time Required _____ |

## II. Meal and Dining Needs

| | | |
|---|---|---|
| **Preparation and Set-Up** | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| **Dining** | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |
| **Clean Up** | Partial ☐ Total ☐ | __ X Daily, 30 Min ☐ Other _____ |

## III. General Housekeeping Needs (not appropriate for children under the age of 12)

Vacuuming Participant's Room/Area: __ X Weekly, 15 Min ☐ Other _____

Sweeping Participant's Room/Area: __ X Weekly, 15 Min ☐ Other _____

Dusting Participant's Room/Area: __ X Weekly, 15 Min ☐ Other _____

Mopping Participant's Room/Area: __ X Weekly, 15 Min ☐ Other _____

Cleaning Participant's Bathroom: __ X Weekly, 30 Min ☐ Other _____

Cleaning Participant's Bedroom: __ X Weekly, 15 Min ☐ Other _____

Participant's Laundry: __ X Weekly, 90 Min ☐ Other _____

## IV. Other Needs

Shopping Assistance*: Errands __ X Weekly, 60 Min ☐ Other _____

Escort __ X Weekly, 60 Min ☐ Other _____

*__not appropriate for recipients under age 21__

Assistance with Communication: __ X Weekly, 60 Min ☐ Other _____

## V. Requested Schedule for Personal Care or Attendant Care Services

***Sunday***

***Monday***

***Tuesday***

***Wednesday***

***Thursday***

***Friday***

***Saturday***

Total Units of Personal Care 1 *requested* (by the participant/caregiver/representative) per week: _____

☐ **Total Units of Personal Care I recommended (by the Service Coordinator) per week:** _____

Total Units of Personal Care 2 *requested* (by the participant/caregiver/representative) per week: _____

☐ **Total Units of Personal Care 2 recommended (by the Service Coordinator) per week:** _____

Total Units of Adult Attendant Care *requested* (by the participant/caregiver/representative) per week: _____

☐ **Total Units of Adult Attendant Care recommended (by the Service Coordinator) per week:** _____

Include justification for or against requested number of weekly units: _____

_____ _____

**Signature of Person Completing Assessment** **Title**

_____

**Date**

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS**
**MR/RD WAIVER**

**AUTHORIZATION FOR UAP ATTENDANT CARE SERVICES**

**TO:** _____

***You are hereby authorized to provide* UAP Attendant Care Services *for:***

**Participant's Name:** _____ **Date of Birth:** _____

**Address:** _____
_____
_____

**Phone Number:** _____ **Medicaid #** _____

***Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service.***

**Start Date:** _____

**Authorized Total:** _____ **Units per week (no more than 28; 1 unit = 1 hour)**

**Service Tasks Requested:**

- ☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
- ☐ Assistance with meals, such as dining, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
- ☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
- ☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
- ☐ Assistance with exercise, positioning, etc.
- ☐ Escort services

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____
_____

Phone # _____

_____ _____
Signature of Person Authorizing Services Date